Families First Health & Support Center • 100 Campus Drive, Suite 12 • Portsmouth, NH 03801
Tel: 603-422-8208 Fax: 603-422-8218
Authorization to Use and Disclose Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

Phone #: _____ Email: _____

I authorize Families First to: ☐ Release my medical information to ☐ Obtain medical information from

Name/Facility: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____ Email: _____

Purpose of Release:

☐ Personal ☐ Transfer of Care ☐ Legal ☐ Insurance ☐ Worker's Comp ☐ Other_____

For personal ONLY choose one: ☐ Pick Up ☐ Mail ☐ Fax **(if less than 15 pages)** ☐ Secure Email

Medical Information to be Released:

☐ Last 1 year of records ☐ Last 3 years of records Only the following: ☐ Physical/Immunizations

☐ Other:_____

I UNDERSTAND THAT MY BASIC MEDICAL AND/OR DENTAL OFFICE NOTES MAY CONTAIN INFORMATION THAT REFERS TO SOME OF THE SENSITIVE INFORMATION LISTED BELOW.

Sensitive Information to be Released:

IMPORTANT - It is extremely important that you check DO or DO NOT for each item listed below. Please do not skip any item as it could impact our ability to fulfill your request and cause additional delays.

Release Records? Check one box in each row:

I	☐ DO	☐ DO NOT want detailed Behavioral/Mental Health records released
I	☐ DO	☐ DO NOT want detailed HIV/Aids/Sexually Transmitted Disease records released
I	☐ DO	☐ DO NOT want detailed Alcohol/Substance Abuse records released
I	☐ DO	☐ DO NOT want detailed Genetic information released
I	☐ DO	☐ DO NOT want detailed Home Visiting records released

To the recipient: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless it is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Authorization

This authorization is valid for **one year** and may be revoked at any time in writing prior to the expiration date, except to the extent Families First has already used or disclosed the information in reliance on my authorization.

I understand that Families First will not condition treatment on my providing this authorization and that I may refuse to sign this authorization, unless the treatment involves research, or is performed only for the purpose of creating protected health information for disclosure to a third party (such as insurance physicals).

I understand that the recipient of some information disclosed under this authorization may re-disclose this information, and the information may be protected by federal or state confidentiality laws.

I understand that NH law permits Families First to charge for the cost of copying the information released under this authorization, up to $15 for the first 30 pages or $.50 per page, whichever is greater. (NH RSA 332-I:1)

_____ _____ _____

Signature of Patient or Personal Representative Relationship (if not patient) Date

*IF YOU ARE TRANSFERRING TO ANOTHER PRIMARY-CARE OR DENTAL PRACTICE, PLEASE TURN OVER FOR IMPORTANT INFORMATION

FOR PATIENTS WHO ARE LEAVING FAMILIES FIRST

I. TRANSFER OF CARE QUESTIONNAIRE

We care what you think! We would like your feedback on the care you received while a patient at Families First and the reason for transferring your care. Please take a few minutes to complete the following questionnaire. Any suggestions and comments are appreciated. Thank you for your time.

1) Why are you leaving Families First? (Please check as many as apply.)

❑ Moving: Please list town and state: _____

❑ Change of Insurance*: Changed to: _____
If you checked this box, did you know Families First accepts private insurance? ☐ Yes ☐ No

❑ Other: Please explain below (use separate page if needed):

2) **Please answer these questions regarding office operations:**

a. Were you able to reach us when you needed assistance?	☐ Yes	☐ No
b. Were you able to make appointments when you needed them?	☐ Yes	☐ No
c. Was the length of time you waited at your appointment reasonable?	☐ Yes	☐ No
d. Was the staff responsive to your needs?	☐ Yes	☐ No

3) **Would you recommend Families First to others for their health care needs?** ☐ Yes ☐ No

4) **Do you have any ideas or suggestions to improve the services at Families First?**

Thank you for taking the time to complete the questionnaire. Your thoughts are valuable to us.
If we can be of further assistance, please do not hesitate to call us.

II. IMPORTANT INFORMATION FOR PATIENTS WHO ARE LEAVING FAMILIES FIRST

1. We will be cancelling any future appointments you may have booked, including dental appointments. (EXCEPTION: Patients under 19 years of age may continue to receive dental services without being a medical patient. If you would like your child to continue with dental, call 603-422-8208, option 3.)
2. We will be closing your case with our health center. If at any time you desire to return to the health center, we would be happy to welcome you back. Please call the office to re-establish care.
3. If you have family members who come to the health center and are also transferring their care, please tell us as soon as possible so we can cancel their future appointments as well. Please list their names here:

   _____
4. If you need additional information, please call Medical Records at 422-8208 ext. 114.